Wisconsin Medicaid Companion Document to HIPAA Implementation Guide: 837 Institutional

PHC 13067 (06/03)

Companion Document Audience

Companion documents are intended for information technology and/or systems staff who will be coding billing systems or software for compliance with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Purpose of Companion Documents

The information contained in this companion document applies to Wisconsin Medicaid and BadgerCare, although the companion document only refers to Wisconsin Medicaid.

The companion documents are designed to be used with HIPAA Implementation Guides. Companion documents provide Wisconsin Medicaid-specific information that details the way to create HIPAA transactions for Wisconsin Medicaid and explains how Wisconsin Medicaid creates HIPAA transactions. Companion documents clarify the HIPAA-designated standards usage but are not intended to supercede them. The purpose of companion documents is to provide trading partners with a guide to communicate the Wisconsin Medicaid-specific information required to successfully exchange transactions electronically with Wisconsin Medicaid.

Wisconsin Medicaid will accept and process any HIPAA-compliant transaction. However, a compliant transaction that doesn't contain Wisconsin Medicaid-specific information, though processed, may be denied for payment. For example, a compliant 837 claim created without a Wisconsin Medicaid recipient identification number will be processed by Wisconsin Medicaid, but will be denied payment.

Companion documents highlight the data elements significant for Wisconsin Medicaid. For transactions created by Wisconsin Medicaid, companion documents explain how certain data elements are processed. Please refer to the companion document first if there is a question about how Wisconsin Medicaid processes a HIPAA transaction. For further information, contact the Division of Health Care Financing (DHCF) Electronic Data Interchange (EDI) Department at (608) 221-9036.

X12 837 Health Care Claim: Institutional

Loop	Element	Name	Instructions
	ISA	Interchange control header	The ISA is a fixed-length record with fixed-length elements. Note: Deviating from the standard's ISA element sizes will cause the interchange to be rejected.
	ISA05	Interchange ID (sender) qualifier	Enter the value "ZZ", mutually defined.
	ISA06	Interchange sender ID	Enter the eight-digit numeric vendor number assigned by Wisconsin Medicaid.
	ISA07	Interchange ID (receiver) qualifier	Enter the value "ZZ", mutually defined.
	ISA08	Interchange receiver ID	Enter "WISC_DHFS".
	GS02	Application sender's code	Enter the same value as ISA06, the eight-digit numeric vendor number assigned by Wisconsin Medicaid.
	GS03	Application receiver's code	Enter "WISC_TXIX" for Wisconsin Medicaid.
	GS08	Version / release / industry identifier code	Enter the value "004010X096A1", the HIPAA mandated implementation guide release for this transaction. Note: This code represents the HIPAA implementation guide with the most recent addenda changes. Using an earlier guide, without the most recent addenda changes, does not comply with the HIPAA rule and will cause the transaction to be rejected.

Loop	Element	Name	Instructions
	BHT03	Reference identification	Make this identifier unique to a single transaction (ST to SE envelope). Repeating a value will cause the transaction to be rejected. Wisconsin Medicaid recommends using a value with an easily identifiable pattern to aid research (e.g., "ANY_GROUP_PRACTICE_20031016" or "ANY GROUP PRACTICE #00001").
	REF02	Reference identification	Enter the value "004010X096A1" to indicate institutional claim. Note: This version includes the addenda.
1000A	NM109	Submitter primary identification number	Enter the same value as ISA06, the eight-digit numeric vendor number assigned by Wisconsin Medicaid. Note: A new vendor number will be issued for submitting HIPAA transactions. This number will replace the submitter's current vendor number.
1000B	NM101	Entity identifier code	Enter the value "40" for receiver.
1000B	NM102	Entity type qualifier	Enter the value "2" for non-person entity.
1000B	NM103	Name last or organization name	Enter "Wisconsin Medicaid" to indicate the claims are being sent to Wisconsin Medicaid.
1000B	NM108	Identification code qualifier	Enter the value "46" for electronic transmitter identification number.
1000B	NM109	Receiver primary identification number	Enter the same value as GS03, "WISC_TXIX" for Wisconsin Medicaid.
2000A	PRV01	Provider code	Enter "BI" to indicate the service facility provider is the same entity as the billing provider or "PT" to indicate the service facility provider is the same entity as the pay-to provider.

Loop	Element	Name	Instructions
2010AA	REF	Billing provider secondary ID	Include this segment if the provider in loop 2010AA is the provider certified by Wisconsin Medicaid to submit claims. Note: Wisconsin Medicaid requires all claims be submitted with the Wisconsin Medicaid billing provider number.
2010AA	REF01	Reference identification qualifier	Enter the value "1D" for Medicaid provider number.
2010AA	REF02	Billing provider additional identifier	Enter the eight-digit billing provider number assigned by Wisconsin Medicaid.
2010AB	NM1	Pay-to provider name	Note: The information in this segment will not be used to determine where to send the provider Remittance and Status Report (R/S) and/or 835 HealthCare Claim Payment/Advice. The R/S Report and/or the 835 will be sent to the entity established during the provider certification process.
2010BA	NM1	Subscriber name	Enter information about the subscriber/recipient in this loop.
2010BA	NM102	Entity type qualifier	Enter the value "1" to indicate the subscriber is a person.
2010BA	NM103	Subscriber last name	Enter the recipient's last name. Note: Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.
2010BA	NM104	Subscriber first name	Enter the recipient's first name. Note: Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Loop	Element	Name	Instructions
2010BA	NM108	Identification code qualifier	Enter the value "MI" for the member identification number.
2010BA	NM109	Subscriber primary identifier	Enter the recipient's 10-digit Medicaid identification number. Note: Do not enter any other numbers or letters. Use the Medicaid identification card or EVS to obtain the correct identification number.
2300	CLM01	Patient account number	Note: Wisconsin Medicaid will process patient account numbers up to 20 characters in length.
2300	CLM02	Total claim charge amount	Enter the total billed amount for the entire claim. Note: Total claim charge amount replaces the use of revenue code 001, used prior to HIPAA to indicate total billed amount. Wisconsin Medicaid will process claims submitted with a negative total billed amount as if the provider submitted a zero total billed amount.
2300	CLM05-1	Facility code value	Enter the first two digits of the type of bill. See the National Uniform Billing Committee (NUBC) manual or Web site www.nubc.org for appropriate value selections.

Loop	Element	Name	Instructions
2300	CLM05-3	Claim frequency code	The third digit of the type of bill, as defined by the NUBC, is the frequency. Use the claim frequency code to indicate if the claim is being submitted for the first time or if it is a replacement/void of a previously adjudicated claim and paid claim. It is always appropriate to use the following values when submitting claims to Wisconsin Medicaid: • Enter the value "1" to indicate it is the first time a claim is submitted to Wisconsin Medicaid. • Enter the value "7" to indicate this claim is replacing a previously submitted and adjudicated claim. Wisconsin Medicaid will null and void the previously submitted claim and completely replace it with this corrected claim. • Enter the value "8" to indicate Wisconsin Medicaid should recoup the previously submitted claim in its entirety. When submitting claims with type of bill 11X, 15X, 16X, 17X, or 18X it is also appropriate to use the following values (if these values are used with other types of bill, the claims will be processed as if a "1" was submitted): • Enter the value "2" to indicate this is the first claim in an interim billing situation. Wisconsin Medicaid will process the claim as if the provider submitted a "1". • Enter the value "3" to indicate this is a continuing claim of an interim billing situation. Wisconsin Medicaid will process the claim as if the provider submitted a "7". See the notes for the usage of "7" above.

Loop	Element	Name	Instructions
2300 (cont.)	CLM05-3	Claim frequency code	• Enter the value "4" to indicate this is the last claim in an interim billing situation. Wisconsin Medicaid will process the claim as if the provider submitted a "7". See the notes for the usage of "7" above. • Enter the value "5" to indicate this is a late billing situation, as defined by the NUBC. Wisconsin Medicaid will adjust the previously submitted claim and add these new service lines to the claim. Note: The use of values "3", "4", "5", "7", and "8" can result in the previously submitted claim being adjusted. Include the Internal Control Number (ICN) from the previously submitted claim in the Original Reference Number segment in loop 2300. Any adjustment request without the previous ICN will be processed as if the provider submitted a "1" in this element. If the previously submitted claim was returned with multiple ICNs from Wisconsin Medicaid, the provider must take that into account when using the values of "3", "4", "5", "'7" and "8." When using the values "3", "4", or "5", the ICN provided should be the one to which the provider wants to add the service lines. When using the value "7", the claim must contain the exact service lines that were previously processed for the ICN being adjusted, in addition to any new service lines. If multiple service lines need to be replaced and they are on different ICNs, an adjustment must be submitted for each ICN. When using the value of "8", an adjustment must be submitted for each ICN.

Loop	Element	Name	Instructions
2300 (cont.)	CLM05-3	Claim frequency code	Electronic adjustments are subject to the same requirements as paper adjustments and therefore may result in a letter to the provider if the requirements are not met. Do not use adjustment values if reconsideration of the original payment is needed. All requests for reconsideration should be submitted on paper with supporting documentation. See the NUBC manual or Web site, http://www.nubc.org/FL4forWeb2_RO.pdf, for additional information on value selections.
2300	DTP01	Date time qualifier	Enter the value "434" for statement dates.
2300	DTP02	Date time period format qualifier	Enter the value "D8" if all the services being billed on the claim were performed on the same date or "RD8" if all the services being billed on the claim were not performed on the same date.
2300	DTP03	Statement from and to date	If "D8" was used in the previous element, enter the date on which all the services were performed. If "RD8" was used in the previous element, enter the date period that covers all the services on the claim.
2300	DTP01	Date time qualifier	Enter the value "435" for admission date.
2300	DTP02	Date time period format qualifier	Enter the value "DT" to indicate the date is displayed in CCYYMMDDHHMM.
2300	DTP03	Admission date and hour	Enter the date the patient was admitted for care.
2300	CL101	Admission type code	Enter the type of admission code. Note: Consult the NUBC manual for appropriate value selections.
2300	CL102	Admission source code	Enter the source of admission code. Note: Consult the NUBC manual for appropriate value selections.

Loop	Element	Name	Instructions
2300	CL103	Patient status code	Enter the patient status code. Note: Consult the NUBC manual for appropriate value selections.
2300	PWK	Claim supplemental information	Note: Prior to the implementation of the 275 Additional Information to Support a HealthCare Claim or Encounter transaction, Wisconsin Medicaid will not be matching attachments to electronic claims. Submit all claims requiring attachments on paper.
2300	AMT01	Amount qualifier code	Enter the value "F3" to indicate patient responsibility.
2300	AMT02	Patient responsibility amount	Enter the patient liability amount as determined by Wisconsin Medicaid.
2300	REF	Original reference number	Include this segment when requesting an electronic adjustment. (The value in CLM05-3 indicates if an adjustment is being requested.) Note: If this segment is not included, the claim will be processed as a new claim and not an adjustment regardless of the value in CLM05-3.
2300	REF01	Reference identification qualifier	Enter the value "F8" for original ICN.
2300	REF02	Original reference number	Enter the most recent ICN assigned by Wisconsin Medicaid.
2300	REF	Peer Review organization (PRO) approval number	Enter the pre-admission review number in this segment.
2300	REF01	Reference identification qualifier	Enter the value "G4" to indicate the pre-admission review (PAR) number.
2300	REF02	Peer review authorization number	Enter the PAR (WIPRO) number.

Loop	Element	Name	Instructions
2300	REF	Prior authorization or referral number	Enter the prior authorization (PA) number in this segment. Note: Wisconsin Medicaid will use the first PA number submitted at the claim level to adjudicate the claim. Wisconsin Medicaid does not use referral numbers in the adjudication of claims.
2300	REF01	Reference identification qualifier	Enter the value "G1" for PA.
2300	REF02	Prior authorization number	Enter Medicaid's seven-digit PA number.
2300	REF	Prior authorization or referral number	Enter the medical record number in this segment.
2300	REF01	Reference identification qualifier	Enter the value "EA" for MRN.
2300	REF02	Reference identification	Enter the MRN.
2300	HI	Health care diagnosis code	Enter the principal diagnosis, admitting diagnosis, and E-code in this segment.
2300	HI01-1	Code list qualifier Code	Enter the value "BK" for Principal Diagnosis.
2300	HI01-2	Industry code	Enter the principal diagnosis code. Note: Wisconsin Medicaid will use up to nine diagnosis codes to process a claim. The principal diagnosis code is included in the nine.
2300	HI02-1	Code list qualifier code	Enter the value "BJ" for admitting diagnosis.
2300	HI02-2	Industry code	Enter the admitting diagnosis code.
2300	HI03-1	Code list qualifier Code	Enter the value "BN" for United States Department of Health and Human Services, Office of Vital Statistics E-code.

Loop	Element	Name	Instructions
2300	HI03-2	Industry code	Enter the value "E".
2300	HI	Other diagnosis information	Enter additional diagnosis codes in this segment, if necessary. Note: Wisconsin Medicaid will use up to eight diagnosis codes in this segment, in addition to the principal diagnosis, to process a claim.
2300	HI01-1 HI02-1 HI03-1 HI04-1 HI05-1 HI6-01 HI7-01 HI8-01	Code list qualifier code	Enter the value "BF" for diagnosis.
2300	HI01-2 HI02-2 HI03-2 HI04-2 HI05-2 HI06-2 HI07-2 HI08-2	Other diagnosis	Enter additional diagnosis codes in order of importance.
2300	HI	Principal procedure information	Enter principal procedure information in this segment.
2300	HI01-1	Code list qualifier code	Enter the value "BR" for the International Classification of Diseases – Ninth Edition – Clinical Modification (ICD-9-CM) principal procedure diagnosis code.
2300	HI01-2	Principal procedure code	Enter the principal procedure code. Note: Wisconsin Medicaid will use up to six procedure codes to process the claim.
2300	HI01-3	Date time period format qualifier	Enter the value "D8" for format CCYYMMDD.
2300	HI01-4	Date time period	Enter the date corresponding to the principal procedure code.

Loop	Element	Name	Instructions
2300	HI	Other procedure information	Enter additional procedure information in this segment. Note: Wisconsin Medicaid will use up to five procedure codes in addition to the principal procedure to process the claim.
2300	HI01-1 HI02-1 HI03-1 HI04-1 HI05-1	Code list qualifier code	Enter the value "BQ" for the International Classification of Diseases – Ninth Edition – Clinical Modification (ICD-9-CM) principal procedure diagnosis code.
2300	HI01-2 HI02-2 HI03-2 HI04-2 HI05-2	Procedure code	Enter additional procedure codes.
2300	HI01-3 HI02-3 HI03-3 HI04-3 HI05-3	Date time period format qualifier	Enter the value "D8" for format CCYYMMDD.
2300	HI01-4 HI02-4 HI03-4 HI04-4 HI05-4	Procedure date	Enter the date corresponding to the additional procedure code.
2300	HI	Occurrence span information	Enter occurrence span information in this segment.
2300	HI01-1 HI02-1 HI03-1 HI04-1 HI05-1	Code list qualifier code	Enter the value "BI" for occurrence span.
2300	HI01-2 HI02-2 HI03-2 HI04-2 HI05-2	Occurrence span code	Enter the occurrence code. Note: Wisconsin Medicaid will use up to five occurrence codes or occurrence code spans to process the claim.

Loop	Element	Name	Instructions
2300	HI01-3 HI02-3 HI03-3 HI04-3 HI05-3	Date time period format qualifier	Enter the value "RD8" for format CCYYMMDD - CCYYMMDD.
2300	HI01-4 HI02-4 HI03-4 HI04-4 HI05-5	Occurrence span code associated date	Enter the date corresponding to the occurrence code.
2300	HI	Occurrence information	Enter the occurrence information in this segment.
2300	HI01-1 HI02-1 HI03-1 HI04-1 HI05-1	Code list qualifier code	Enter the value "BH" for occurrence code.
2300	HI01-2 HI02-2 HI03-2 HI04-2 HI05-2	Occurrence code	Enter the occurrence code. Note: Wisconsin Medicaid will use up to five occurrence codes or occurrence code spans to process the claim.
2300	HI01-3 HI02-3 HI03-3 HI04-3 HI05-3	Date time period format Qualifier	Enter the value "D8" for format CCYYMMDD.
2300	HI01-4 HI02-4 HI03-4 HI04-4 HI05-4	Occurrence or occurrence span code associated date	Enter the date corresponding to the occurrence code.
2300	HI	Value information	Enter value code information in this segment.
2300	HI01-1 HI02-1 HI03-1 HI04-1 HI05-1	Code list qualifier code	Enter the value "BE" for value code.

Loop	Element	Name	Instructions
2300	HI01-2 HI02-2 HI03-2 HI04-2 HI05-2	Value code	Enter the value code. Note: Wisconsin Medicaid will use up to five value codes to process the claim.
2300	HI01-5 HI02-5 HI03-5 HI04-5 HI05-5	Value code associated amount	Enter the dollar amount corresponding to the value code.
2300	HI	Condition information	Enter condition code information in this segment.
2300	HI01-1 HI02-1 HI03-1 HI04-1 HI05-1	Code list qualifier code	Enter the value "BG" for condition code.
2300	HI01-2 HI02-2 HI03-2 HI04-2 HI05-2	Condition code	Enter the condition code. Note: Wisconsin Medicaid will use up to five condition codes to process the claim.
2300	QTY	Claim quantity	This segment repeats multiple times. Use one iteration for covered days and a second iteration for non-covered days. Note: This segment is required for all inpatient claims, including nursing home claims.
2300	QTY01	Quantity qualifier	Enter the value “CA” for covered days or "NA" for non-covered days.
2300	QTY02	Claim days count	Enter the number of covered or non-covered days. Note: This element is required on all inpatient claims, including nursing home claims.
2310A	NM101	Entity identifier code	Enter the value "71" for attending physician.
2310A	NM103	Attending physician last name	Enter the attending provider’s last name.

Loop	Element	Name	Instructions
2310A	REF01	Reference identification qualifier	Enter the value "1D" for Medicaid number.
2310A	REF02	Attending physician secondary identifier	Enter the eight-digit provider number assigned to the attending physician by Wisconsin Medicaid.
2310B	NM101	Entity identifier code	Enter the value "72" for operating physician.
2310B	NM103	Operating physician last name	Enter the operating physician's last name.
2310B	REF01	Reference identification qualifier	Enter the value "1D" for Medicaid number.
2310B	REF02	Operating physician secondary identifier	Enter the eight-digit provider number assigned to the operating physician by Wisconsin Medicaid.
2310E	REF01	Reference identification qualifier	Enter the value "1D" for Medicaid number.
2310E	REF02	Facility secondary identifier	Enter the eight-digit provider number assigned to the facility by Wisconsin Medicaid.

Loop	Element	Name	Instructions

2320	SBR	Other subscriber information	Include this loop when any of the following occur:
			• The claim will be processed by multiple payers.
			• The recipient has commercial health insurance or commercial HMO coverage, but the claim was not billed to the other payer for reasons including, but not limited to:
			  • The recipient denied coverage or will not cooperate.
			  • The provider knows the service in question is not covered by the carrier.
			  • The recipient's commercial health insurance failed to respond to initial and follow-up claims.
			  • Benefits are not assignable or cannot get assignment.
			  • Benefits are exhausted.
			• The claim was not sent to Medicare Part A, the billing provider identified is certified for Medicare Part A, the recipient is eligible for Medicare Part A, and the service is usually covered by Medicare Part A but not in this circumstance.
			• The claim was not sent to Medicare Part B, the billing provider identified is certified for Medicare Part B, the recipient is eligible for Medicare Part B, and the service is usually covered by Medicare Part B but not in this circumstance.

Loop	Element	Name	Instructions
2320	SBR09	Claim filing indicator code	Enter the type of payer. Wisconsin Medicaid uses this information when evaluating other insurance information. If this claim was not submitted to a commercial health insurance plan or commercial HMO plan based on the reasons listed for the SBR segment in loop 2320, enter one of the following values: • "12" for Preferred Provider Organization (PPO). • "13" for Point of Service (POS). • "14" for Exclusive Provider Organization (EPO). • "BL" for Blue Cross/Blue Shield. • "CH" for Champus. • "CI" for Commercial Insurance Co. • "DS" for Disability. • "HM" for HMO. • "VA" for Veteran Administration Plan. If this claim was not submitted to Medicare based on the reasons listed for the SBR segment in loop 2320, enter one of the following values: • "MA" for Medicare Part A. • "MB" for Medicare Part B. • "16" for HMO Medicare risk.
2320	CAS	Claim level adjustment	Include this segment when another payer has made payment at the claim level. If the other payer returned an 835 HealthCare Claim Payment/Advice, the CAS segment from the 835 should be copied to this CAS. Note: Wisconsin Medicaid will use the information in the CAS segment in place of the "other insurance indicator" and "Medicare disclaimer code" submitted prior to HIPAA. If this iteration of loop 2320 contains information from a Medicare payer, Wisconsin Medicaid will also look for Medicare's coinsurance, copayment and deductible in this segment.

Loop	Element	Name	Instructions
2320	AMT	Payer prior payment	This segment contains the amount paid on this claim by the payer within this 2320 loop.
2320	AMT01	Amount qualifier code	Enter the value "C4" for prior payment-actual.
2320	AMT02	Other payer patient paid amount	Enter the amount paid on this claim by the payer within this 2320 loop.
2320	AMT01	Amount qualifier code	Enter the value "B6" for allowed amount.
2320	AMT02	Allowed amount	Enter the other payer's allowed amount. Note: If this claim was not submitted to another payer, zero must be indicated as the allowed amount.
2320	AMT01	Amount qualifier code	Enter the value "A8" for non-covered charges –- actual.
2320	AMT02	Non-covered charge amount	Enter the non-covered charges.
2320	MIA	Medicare inpatient adjudication information	Include this segment when it was returned in the 835 HealthCare Claim Payment/Advice from a previous payer or if this iteration of 2320 is being used to indicate that an inpatient hospital or nursing home claim was not submitted to another payer based on the notes in the SBR segment of loop 2320 of this document.
2320	MIA05	Remark code	If the claim was not submitted to another payer, enter "MA07" in this element.
2320	MOA	Medicare outpatient adjudication information	Include this segment when it was returned in the 835 HealthCare Claim Payment/Advice from a previous payer or if this iteration of 2320 is being used to indicate an outpatient claim was not submitted to another payer based on the notes in the SBR segment of loop 2320 of this document.
2320	MOA03	Remark Code	If the claim was not submitted to another payer, enter "MA07" in this element.

Loop	Element	Name	Instructions
2330B	NM109	Other payer primary identifier	Enter the other payer's identifier. Note: Wisconsin Medicaid will use this number in combination with loop 2430 to calculate other insurance and Medicare payments.
2330B	DTP03	Adjudication or payment date	Enter Medicare's claim paid date.
2400	SV201	Service line revenue code	Enter the revenue code for the services performed. Note: Revenue codes are four digits. Note: Nursing home claims submitted for services provided prior to 10/1/03 should be submitted with the two-digit local level of care or ancillary code with two proceeding zeros. For example, level of care code 20 should be submitted as 0020. Nursing home claims for dates of service after 10/1/03 must be submitted using revenue codes.
2400	SV202	Composite medical procedure identifier	Enter a Healthcare Common Procedure Coding System (HCPCS) code, when necessary to supplement the revenue code.
2400	SV202-1	Product or service ID qualifier	Enter the value "HC" for HCPCS code. Note: Because the AMA's CPT codes are also level 1 HCPCS codes, they are reported under qualifier HC.
2400	SV202-2	Procedure code	Enter the HCPCS/CPT code for the services performed.
2400	SV202-3	HCPCS modifier 1	Enter a HCPCS/CPT modifier code, if necessary to clarify the procedure code.
2400	SV202-4	HCPCS modifier 2	Enter a HCPCS/CPT modifier code, if necessary to clarify the procedure code.
2400	SV202-5	HCPCS modifier 3	Enter a HCPCS/CPT modifier code, if necessary to clarify the procedure code.
2400	SV202-6	HCPCS modifier 4	Enter a HCPCS/CPT modifier code, if necessary to clarify the procedure code.

Loop	Element	Name	Instructions
2400	SV203	Line item charge amount	Enter the billed amount for each service line. Note: Wisconsin Medicaid will process claims submitted with a negative service line billed amount as if the provider submitted a zero service line billed amount.
2400	SV204	Unit or basis for measurement	Enter the value "DA" for days or "UN" for units.
2400	SV205	Service unit count	Enter the number of days or units for the services provided.
2400	SV207	Line item denied charge or non-covered charge amount	Enter the service line non-covered amount.
2400	DTP01	Date time qualifier	Enter the value "472" for service dates.
2400	DTP02	Date time period format qualifier	Enter the value "D8" to indicate a single date of service or "RD8" to indicate a range of service dates for the service line. Note: When "RD8" is used on outpatient claims, Wisconsin Medicaid will assume the exact same service, including the number of units, was performed on each day within the range.
2400	DTP03	Service date	Enter the date(s) the procedure was performed. Note: Wisconsin Medicaid requires service line dates on all outpatient and nursing home claims.
2420A	NM101	Entity identifier code	Enter the value "71" for attending physician.
2420A	NM103	Attending physician last name	Enter the attending physician's last name.
2420A	REF01	Reference identification qualifier	Enter the value "1D" for Medicaid number.

Loop	Element	Name	Instructions
2420A	REF02	Attending physician secondary identifier	Enter the eight-digit provider number assigned to the attending physician by Wisconsin Medicaid.
2420B	NM101	Entity identifier code	Enter the value "72" for operating physician.
2420B	NM103	Operating physician last name	Enter the operating physician's last name.
2420B	REF01	Reference identification qualifier	Enter the value "1D" for Medicaid number.
2420B	REF02	Operating physician secondary identifier	Enter the eight-digit provider number assigned to the operating physician by Wisconsin Medicaid.
2430	SVD01	Payer identifier	Enter the payer identifier when another payer has paid on the service line.
2430	SVD02	Service line paid amount	Enter the amount the other payer paid on the service line.
2430	CAS	Service line adjustment	Include this segment when another payer has made payment at the service line. If the other payer returned an 835 remittance with a service line CAS, the CAS segment from the 835 should be copied to this CAS. Note: Wisconsin Medicaid will use the information in the CAS segment in place of the information submitted prior to HIPAA that is referred to as the "other insurance indicator" and "Medicare disclaimer code". If this iteration of loop 2430 contains information from a Medicare payer, Wisconsin Medicaid will also look for Medicare's coinsurance, copayment and deductible.
2430	DTP	Service line adjudication date	Include this segment when another payer has made payment at the service line of this claim.

Loop	Element	Name	Instructions
2430	DTP01	Date/time qualifier	Enter the value "573" for the claim paid date.
2430	DTP02	Date time period format qualifier	Enter the value "D8" to indicate format CCYYMMDD.
2430	DTP03	Service adjudication or payment Date	Enter the date the other payer paid the claim.